A. General Information

Covered nursing home services are medically necessary services provided by a certified nursing home to a nursing home recipient and prescribed by a physician in a plan of care.

Medicaid-certified nursing homes are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Certified facilities, including distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Facilities that meet the federal definition of institutions that primarily accept and treat persons with mental illness are called institutions for mental diseases (IMDs). All facilities that meet the definition of an IMD are notified by the Department of Health and Social Services (DHSS). Wisconsin Medicaid does not cover any services provided to residents of an IMD who are between the ages of 21 and 64. This means that residents of an IMD between 21 and 64 are not eligible for Medicaid services, including all separately billable Medicaid services.

B. Services Reimbursed in the Nursing Home Daily Rate

For NFs and FDDs, Medicaid nursing home payment policies and principles are used and are contained in the annual nursing home payment formula or Methods of Implementation. The payment formula is an annual formula corresponding to the State Fiscal Year (July-June), and formula updates and modifications are generally effective each July 1.

The setting of rates for each certified-nursing home is the responsibility of Medicaid Regional Auditors. This includes setting interim rates (if applicable), rates for new operations, facility phase down rates, and final rates. Information on the formula with respect to individual nursing homes can be obtained by contacting the home's regional auditor. Appendix 21of this handbook contains the addresses of Medicaid Regional Auditors.

The payment formula must comply with federal law and regulations which state that Medicaid payments to nursing facilities "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable laws, regulations, and quality and safety standards...." (SSA 1902 (a)(13)(A)). The law further requires that the State (Medicaid) Agency "take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...) of complying with (standards)" (SSA 1902 (a) (13) (A)).

Using this norm, the costs incurred by efficiently and economically-operated facilities for all routine, day-to-day health care services and materials provided to recipients by a nursing home are reimbursed in the daily rate. Every certified nursing facility has daily rates calculated for each accommodation code or care level served in the facility with the rate based upon a payment formula. Please refer to the annual Methods for further information and specifics on the formula.

According to HSS 107.09, Wis. Admin. Code, routine services and costs include:

1. nursing services;
2. special care services, including activities, therapies, recreation, social services, and religious services;

B. Services Reimbursed in the Nursing Home Daily Rate (continued)

3. supportive services, including dietary, housekeeping, maintenance, institutional and personal laundry services, but excluding personal dry cleaning services;
4. administrative and other indirect services;
5. physical plant, including depreciation, insurance, and interest on plant;
6. property taxes;
7. over-the-counter (OTC) analgesics and medically necessary non-covered OTC drugs;
8. non-medical transportation services (medical transportation is separately reimbursable; see the annual Methods for specific information);
9. services for developmentally disabled residents; and
10. supplies and equipment. This includes dietary supplies, incontinence supplies, personal comfort supplies, medical supplies and equipment, and other similar items. All of these items are associated with a recipient's personal living needs in normal and routine nursing home operations. Section 5.000 of the annual Methods of Implementation contains a list of these items.

Certain durable medical equipment (DME) and disposable medical supplies (DMS) are separately reimbursable for nursing home recipients. Please refer to the section below on DME/DMS, the DME (Part N) provider handbook, along with the DMS Index and DME Index for further information and specifics on DME and DMS. The DME (Part N) provider handbook and the Indices applies to all Medicaid recipients, including all Title XIX nursing home residents. The DME Index and DMS Index identify DME and DMS items included or excluded in the nursing home daily payment rate.

C. Ancillary Add-ons to the Nursing Home Daily Rate

Certain services that are normally billed separately from the nursing home daily rate may be included as an ancillary add-on to the nursing home daily rate. An add-on is for specifically-identified covered services and materials which could be billed separately to Wisconsin Medicaid by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

Nursing homes need prior approval from Medicaid regional auditors for ancillary add-ons.

Nursing homes who request ancillary add-ons must be able to document that these services will cost no more than if they are billed separately, according to HSS 107.09(4)(1), Wis. Admin. Code. Nursing homes interested in ancillary add-ons should contact their Medicaid regional auditor.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate

Ancillary services for nursing home residents are those which are considered non-routine and, thereby, not included in the nursing home daily rate. Certain covered ancillary services are separately reimbursable from the nursing home daily rate. The costs incurred for ancillary services are billed through ancillary codes.

Wisconsin Medicaid requires prior approval for ancillary services except medical transportation.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate (continued)

For lab services (code "N3" below) and radiology/x-ray (code "N4" below), prior approval is required from the BHCF Nursing Home Section Regional Auditors. For the ventilator care, AIDS care and private room requests (codes "N6," "N7," and "N9" below), prior authorization is required from the BHCF Medicaid Audit Section.

Nursing home providers do not need separate Medicaid certification to provide ancillary services. In some cases, nursing homes may need to perform additional services to qualify for Medicaid ancillary coverage.

The valid ancillary services and their corresponding codes are:

N2 Transportation: This is medical transportation of a recipient to obtain health treatment or care. The treatment or care must be prescribed by a physician as medically necessary and must be performed at a physician's office, clinic, or other recognized medical treatment center. The nursing home must provide the transportation in its controlled equipment and by its staff, or by common carrier (e.g., bus, taxi). The charges are cost per mile, not staff cost. Billings may not exceed the nursing home's actual cost. Routine transportation to activities, such as social events, is part of the daily rate. For specialized motor vehicle transportation, please see *Wisconsin Medicaid Updates* on specialized motor vehicle transportation services.

N3 Laboratory Services.

N4 Radiology Services.

N6 Private Room: A private room may be prior authorized under certain medically necessary conditions for isolation per HSS 132 and Centers for Disease Control guidelines. Please contact the BHCF Medicaid Audit Section for more information on qualifying conditions. An approved private room rate is the facility's Wisconsin Medicaid rate plus the difference between the facility's daily private-pay semi-private room rate and private-pay private room rate up to $35. Documentation of the rate differential must accompany the prior authorization request.

N7 Ventilator Care: Wisconsin Medicaid provides additional reimbursement for ventilator dependent recipients admitted to nursing homes authorized to provide ventilator dependent care. The current ventilator rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

N9 AIDS Care: A provider accepting recipients with a diagnosis of AIDS may receive additional reimbursement for the recipient. The current AIDS rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

E. Other Ancillaries

Other Ancillaries

Nursing facilities may bill other ancillary services that do not have "N" codes, subject to BHCF approval. For example, certain supplies and equipment for tracheostomy care and exceptional supply needs for ventilator dependent patients and patients receiving similar care. Other supplies and equipment may be reimbursable to a nursing facility separate from the daily rate without prior authorization and billed on the HCFA 1500 claim form. Supplies and equipment listed in Sections 6.310 and 5.160 may be reimbursed separate from the daily rate subject to prior authorization. Supplies listed in Sections 5.110-5.150 are included in the daily rate. For identification of specific items of equipment and supplies to determine whether the items are in the daily rate or separately billable, please refer to the DME Index and DMS Index. Please see Sections II-I and II-J, along with Section III on prior authorization for additional information.

F. Nursing Home Head Injury Patients

Nursing Home Head Injury Patients

According to Section 4.692 of the Nursing Home Methods, approved facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates are all-inclusive, including all durable medical supplies and exceptional supplies. Rates further include bedhold. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department of Health and Social Services (DHSS) based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the DHSS.

Treatment program and rates must be appropriate and receive prior approval of the BHCF Medicaid Audit Section and Nursing Home Section. Effective July 1, 1994, the billing for such treatment was converted from an ancillary billing to an accommodation code. Refer to Section I-B of this handbook for a listing of accommodation codes.

Facilities interested in the program requirements and information for treatment of head injured persons should contact:

Director
Bureau of Health Care Financing
P.O. Box 309
Madison WI 53701-0309

G. Services Provided by Other Providers

Generally, when a billable, covered service is provided to a Medicaid nursing home resident by an independent provider of service (e.g., dentist outside of the nursing home), reimbursement may be claimed only by the independent provider under the independent provider's number. Medicaid certification and program requirements for that provider type apply.

H. Bedhold

General Information

Bedhold is covered for therapeutic leaves of any length and for hospital stays up to 15 days. Payment will only be made if the nursing home meets the requirements of the qualifying criteria. Specific bedhold requirements are communicated in BQC program memoranda. The nursing home must have an occupancy threshold of 95 percent for the previous month or have had eight vacant beds or less in the previous month to qualify for Medicaid bedhold coverage. Accommodation codes for billing hospital bedhold charges or therapeutic leaves are in Appendix 15 of this handbook.

Bedhold Days for Hospital Visits

Hospitalization bedhold days are reimbursable for up to 15 days per hospital stay. There is no limit on the number of stays per year. Beyond 15 days, hospital bedhold is a noncovered service.

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

2. All hospital bedhold days up to 15 days are considered covered services ; therefore, bedhold charges to the recipient, family, or friends are prohibited. No resident or third party may be charged for covered, bedhold days for a Wisconsin Medicaid recipient. With the prior consent of the recipient or a legal representative, bedhold may be charged to hold the bed after 15 days of Medicaid-covered hospital, bedhold services.

H. Bedhold (continued)

3. Recipients cannot be administratively discharged from the nursing home unless they remain in the hospital longer than 15 days and no agreements have been made to hold the bed through payments by the resident, family or guardian and the resident and legal representative or family have been given a 30 day notice of involuntary discharge through the federal requirements for discharge under 42 CFR 483.12.

4. Claims for bedhold days during leaves for hospitalization cannot be submitted when it is known in advance that a recipient will not return to the nursing home following the hospital stay.

Providers can claim only the days prior to:

- the recipient's return to the nursing home;
- the recipient's death in the hospital;
- notification of the recipient's terminal condition; or
- the recipient's need for discharge to another facility.

Bedhold Days for Therapeutic Visits

Therapeutic visits are overnight visits (one or more nights) by a recipient with relatives or friends. Bedhold days for therapeutic visits are reimbursable if the recipient requests leave days for visits, and if the recipient's physician approves the leave in the physician's plan of care for the recipient. This statement must include the rationale for and the anticipated goals of the leave, as well as any limitations on the frequency or duration of leaves. The provider must note any time there is a change in the recipient's condition in the plan of care. The following information also applies to bedhold days for therapeutic visits:

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

2. All therapeutic leaves of absence for visits are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.

3. Bedhold days for a therapeutic visit leave, when it is known in advance that a recipient does not plan to return to the facility following the therapeutic visit, are not covered under Wisconsin Medicaid.

4. A staff member designated by the administrator (e.g., social service director or nursing service director) must document the recipient's absence in the recipient's records and approve each individual leave based upon physician order(s).

Bedhold Days for Therapeutic/Rehabilitative Programs

Bedhold days for therapeutic or rehabilitative programs are covered when:

1. The therapeutic/rehabilitative program, in the opinion of the recipient's physician, contributes to the recipient's mental, physical, or social development according to the recipient's plan of care. The program must meet the definition of a therapeutic or rehabilitative program:

H. Bedhold (continued)

"A formal or structured medical or health care activity which is designed to contribute to the mental, physical or social development of its participants, and is certified or approved, or its sponsoring group is certified or approved, by a national standard-setting or certifying organization when such an organization exists." (HSS 101.03[165], Wis. Admin. Code)

2. Upon request from Wisconsin Medicaid, the nursing home must submit in writing the following information regarding the recipient:

   - dates of the program's operation;
   - number of participants;
   - identification of the program's sponsorship;
   - anticipated program goals and how the goals will be accomplished (treatment modalities); and
   - the program's leadership or faculty and their credentials.

3. Each time the recipient attends a therapeutic or rehabilitative program, the recipient's physician must include:

   - a written statement in the plan of care approving for the recipient's participation in the program;
   - the goals of the program which apply to the recipient; and
   - the duration or frequency of the recipient's participation.

4. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

5. Leaves of absence to attend therapeutic or rehabilitative programs are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.

6. A staff member designated by the administrator (e.g., director of nursing service or social service director) must document the recipient's absence in the recipient's chart.

7. The bedhold for therapeutic/rehabilitation programs cannot be claimed if the recipient is receiving these services at another in-state or out-of-state nursing home.

8. There is no limitation on bedhold days for therapeutic/rehabilitation leave as long as all other criteria are met.

For additional information on bedhold policies, such as resident transfer and discharge rights requirements and Medicare Part A implications for bedhold, please refer to the BQC Memoranda on this subject. Copies of BQC Memos can be obtained directly from the BQC.

I. DME and Wheelchairs Provided to Nursing Home Recipients

General Information

DME and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Wisconsin Medicaid recipients without charge to the recipient, the recipient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate. All items must be suitable for use in the recipient's place of residence.

I. DME and Wheelchairs Provided to Nursing Home Recipients (continued)

Most DME is reimbursed through the nursing home daily rate. Certain DME is separately reimbursable for nursing home recipients. Some DME requires prior authorization, and some DME can be billed separately from the daily rate without prior authorization.

Wheelchairs Reimbursable Through the Nursing Home Daily Rate

All manual wheelchairs without a custom adaptive positioning system are reimbursable through the nursing home daily rate.

Wheelchairs Separately Reimbursable and Not Included in the Nursing Home Daily Rate

Under certain conditions, manual wheelchairs with a custom adaptive positioning system, and all power/motorized wheelchairs are not included in the nursing home daily rate. Also repairs of a resident-owned power wheelchair or a wheelchair with a custom adaptive positioning system are reimbursed separately by Wisconsin Medicaid. Repairs over $150 require prior authorization. This topic is addressed in more detail in Sections II-D, II-J, and III-H of the Part N DME Handbook and its updates.

DME and Wheelchairs

Under certain conditions, DME and wheelchairs may be billed separate from the nursing facility payment rate with prior authorization. Nursing homes can bill directly or use a certified DME provider to bill certain DME. Please see Section II-J of the DME (Part N) provider handbook for information on this topic and the DME Index for identification of which DME items are in the rate and which can be billed separately. *Wisconsin Medicaid Updates* on DME and wheelchairs provide current information on this topic.

Separate payment for certain DME may be allowed if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. Some of these items require prior authorization and some do not. These items include, but are not limited to, orthoses (see Part N, Section II-F), prostheses (including hearing aids) (see Part N, Section II-H and the Wisconsin Medicaid audiology handbook), orthopedic or corrective shoes (see Part N, Section II-G), and pressure relief beds (see Part N, Section III-B). Please see Sections II and III of the DME (Part N) provider handbook and the DME Index for covered services and prior authorization policies for DME for nursing home residents.

According to HSS 107.09(4), Wis. Admin. Code, the following items are not included in calculating the daily nursing home rate but may be reimbursed separately: oxygen in liters, tanks, or hours, including tank rentals and monthly rental fees for concentrators (see Part N, Sections II-J and III-H); and tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the DHSS. The guidelines and limitations are contained in the DME (Part N) provider handbook, Section II-J, *Wisconsin Medicaid Updates*, and the DME Index.

DME and DMS exceptions to the daily rate (e.g. oxygen and supporting respiratory equipment), are billed on the HCFA 1500 claim form. Please see Section IV of this handbook for information on claims submission.

J. DMS Provided to Nursing Home Recipients

General Information

DMS are generally included in the daily rate for nursing homes and are not separately reimbursable. A provider may receive separate payment for DMS provided to a nursing home recipient under only these circumstances:

1. If recipients specifically elect to purchase DMS (other than nursing home stock items) with their personal allowance. This is only for DMS that is considered not medically necessary.
2. If recipients are eligible as a result of their medical conditions to receive exceptional supplies. Under this situation, prior authorization is required. Please see The DME (Part N) provider handbook, Section II-J for further information.
3. If the DMS items are identified on the DMS Index as not included in the nursing home rate but separately reimbursable on the HCFA 1500 claim form.

The DMS Index, as updated, provides the list of DMS with an identification of whether the supplies are included, or not included, in the daily rate. Nursing facilities automatically receive copies of, and updates to, the DMS Index.

K. Medically Necessary Noncovered Services

Resident Liability

Under Wisconsin Medicaid, resident liability refers to the amount of resident income which is available, according to recipient eligibility criteria, to apply on a monthly basis towards monthly cost of care. The resident liability reduces the amount paid by Wisconsin Medicaid.

General Information

Some medically necessary services are not covered by Wisconsin Medicaid for nursing home recipients. However, it is possible to have the costs for these services identified and deducted from the resident liability amount. The resident liability amount is the amount of recipient income that is available to apply toward the cost of care. In addition, there is a personal needs allowance for resident's personal needs which may be used to pay for Medicaid noncovered, nonmedically necessary items and services under certain conditions. This is not part of the resident liability. See Section II-M of this handbook for more information.

Federal regulations state that only medically necessary noncovered services may be charged against the liability without the resident's consent and allow Wisconsin Medicaid to establish reasonable limits on the necessary noncovered medical services which can be charged against the resident liability.

Items and Services That May Be Charged Against the Resident Liability

The following noncovered services have been determined to be medically necessary and are the only noncovered services that may be charged against the resident liability. These items and services may *not* be charged against the personal needs allowance.

1. Noncovered services or items from the following specific sections of HSS 107 Wis. Admin. Code.

HSS	*Service Area*	*Noncovered Services*
107.20(4)	Vision	a. anti-glare coating

K. Medically Necessary Noncovered Services (continued)

107.07(4)	Dental	a. fluoride mouth rinse b. panoramic radiographs which include bitewings c. professional visits, other than for the annual examination of a nursing home resident d. dispensing of drugs e. surgical removal of erupted teeth, except as otherwise stated in sub(3) f. alveoplasty and stomatoplasty g. bitewing x-rays, except as otherwise stated in sub(3)
107.24(5)	Durable Medical	a. foot orthoses or orthopedic or corrective shoes for the conditions listed in HSS 107.24(5)(a)

2. Eyeglass frames or lenses beyond the original pair and one unchanged prescription replacement pair from the same provider in a 12-month period which have been denied through prior authorization by Wisconsin Medicaid.

3. For dental services, recent budget changes have made the following dental services noncovered services, specifically, complete and partial dentures, denture relines, denture repairs and fixed prosthodontics.

Enter noncovered services charged against the resident liability on the UB-92 claim form. The dollar amount applied against the resident liability reduces the amount paid by Wisconsin Medicaid. The liability amounts are shown using the billing codes in Section II-L of this handbook.

L. Codes for Medically Necessary Noncovered Services

Noncovered, medically necessary, physician-prescribed services and items must be included on the UB-92 claim form. The appropriate codes are listed below. The resident liability must be used to pay for these items or services. If there is resident liability, it must first be exhausted before the personal needs allowance or family personal funds may be considered to pay for these items. (Refer to Section II-M below for more information.) The codes are:

M6 - Noncovered vision services
M7 - Noncovered dental services
M8 - Other noncovered services

These are the only valid codes to use for this purpose.

M. Nonmedically Necessary Noncovered Services

Personal Needs Allowance

The recipient may be financially responsible for certain noncovered items and nonmedically necessary services. A portion of a resident's funds, as prescribed in 42 CFR 483.10, is available for a living allowance or personal needs allowance. This allowance may be used to pay for certain Medicaid noncovered items and services. The recipient can choose to apply the allowance to obtain certain noncovered services and items, such as personal comfort items not included in the nursing facility payment rate. Resident personal funds cannot be used without the prior written consent of the recipient. The personal needs allowance is set by s.49.45(7)(a), Wis. Stats. and is currently $40 per month.

M. Nonmedically Necessary Noncovered Services (continued)

Private Rooms

Private rooms are not a covered service in a nursing home's daily reimbursement rate, except for medically-necessary isolation precautions. However, if a recipient, or a recipient's legal representative, chooses a private room with the full knowledge and acceptance of the financial liability, the recipient may reimburse the nursing home for a private room under the following conditions:

- the recipient or a legal representative is informed of the personal financial liability if the recipient chooses a private room;
- pursuant to HSS 132.31(1)(d) Wis. Admin. Code, the recipient or a legal representative documents the private room choice in writing;
- the recipient or a legal representative is personally liable for no more than the difference between the nursing home's private-pay rate for a semi-private room and the private-pay, private room rate; and
- if at any time this differential rate changes, the recipient or a legal representative must be notified by the nursing home administrator within 15 days and a new consent agreement must be reached.